No. 05-1954

In the United States Court of Appeals for the Eighth Circuit

BELINDA SMITH
Plaintiff/Appellant

V.

JO ANNE B. BARNHART, COMMISSIONER,
SOCIAL SECURITY ADMINISTRATION
Defendant/Appellee

ON APPEAL FROM THE
UNTIED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
WESTERN DIVISION

BRIEF OF APPELLANT

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SUMMARY OF THE CASE AND REQUEST FOR ORAL ARGUMENT

This is an appeal by Belinda Smith from an Order of the United States District Court for the Eastern District of Arkansas, affirming the Commissioner's decision which denied Smith's application for supplemental security income (SSI) (Title XVI). Smith filed an application for benefits in March 2001. Her claim was denied at all administrative levels. Clay sought review of the Commissioner's decision in the United States District Court for the Eastern District of Arkansas, arguing that it was not supported by substantial evidence. On March 10, 2005, the district court affirmed the Commissioner's decision. This appeal followed.

The appellant believes that oral argument would be of material assistance to the Court in deciding this case, and thus, respectfully requests that her attorney be given fifteen minutes in which to present oral argument.

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JURISDICTIONAL STATEMENT

(i) This appeal is from an order filed on March 10, 2005, in the United States District Court for the Eastern District of Arkansas, Western Division, Civil No. 4:03CV00721, issued by the Honorable Jerry W. Cavaneau, United States Magistrate Judge.

(ii) The United States District Court for the Eastern District of Arkansas had proper jurisdiction to review a final decision of the Commissioner of the Social Security Administration pursuant to 42 U.S.C. § 405(g).

(iii) Pursuant to 28 U.S.C. § 1291, this Court has jurisdiction to review the final judgment of the United States District Court entered on March 10, 2005, from which the appellant filed a timely notice of appeal on March 30, 2005.

STATEMENT OF THE ISSUE

Whether the Commissioner's decision that Belinda Smith is not disabled within the meaning of the Social Security Act is supported by substantial evidence on the record as a whole.

Frankl v. Shalala, 47 F.3d 935 (8th Cir. 1995)

Battles v. Shalala, 36 F.3d 43 (8th Cir. 1994)

Barrett v. Shalala, 38 F.3d 1019 (8th Cir. 1994)

STATEMENT OF THE CASE

Belinda Smith filed an application for supplemental security income (SSI) on March 22, 2001. (Tr. 62-66). After a hearing, the ALJ issued an unfavorable decision on May 17, 2003. (AD 1-6; Tr. 9-14). On August 14, 2003, the Appeals Council denied Smith's request for review. (AD 7-9; Tr. 2-4). Thus, the ALJ's decision was the final decision of the Commissioner and it was from this decision that Smith sought judicial review. On March 10, 2005, the district court affirmed the Commissioner's denial of Smith's claim. (AD 9-17). This appeal followed.

STATEMENT OF FACTS

A. Testimonial and documentary evidence.

Belinda Smith is a thirty-year-old woman with a high school education who worked in the past as a certified nursing assistant (CNA). She was placed in some special education classes during school. She is five feet six inches tall and weighs 220 pounds. Smith was not represented by counsel in the proceedings before the agency. The administrative hearing lasted only twenty minutes. (Tr. 28-29, 38, 78, 94).

Smith testified at the hearing that she is unable to work due to three "strokes," arthritis, and a seizure disorder. She had seizures as a child and now is having them again. She is taking Dilantin, but it is not controlling the seizures. Smith described having what she called a "stroke" in 1994 when she was picking corn and suffered a severe migraine headache. She later suffered another severe migraine that sent her to the hospital. Smith further testified that she suffers from chronic obstructive pulmonary disease (COPD), for which she takes updrafts every four hours. She also takes Paxil for depression and suffers from thoracic outlet syndrome. She can tell a difference when she stops taking the Paxil. (Tr. 29-31, 32, 36).

Regarding her daily activities, Smith testified that she cares for her two children, ages five and eight. She has been unable to drive for several months due to her seizures. Her doctor told her not to cook or use the stove because she could have a seizure and burn herself or knock something off the stove and burn

one of her children. She occasionally tries to pick up around the house. She tries to do some crafts sometimes, but has difficulty due to lack of circulation in her arms. She occasionally visits relatives outside the home or goes to church. She does not watch much television, but does read some. Her sister usually does the shopping. (Tr. 31-33).[1]

Smith further testified that her doctor told her not lift more than five or ten pounds. She has some difficulty with standing and walking due in part to endometriosis and pelvic inflammatory disease (PID). Her uterus is prolapsed and once her doctors get her seizure disorder stabilized, she will undergo a hysterectomy. She is unable to walk a few blocks and has a handicapped parking permit due to her COPD. She sometimes has panic attacks. (Tr. 33-34).

Sherry Bridges, Smith's sister, also testified at the hearing. She stated that she lives with Smith and that there are some days that Smith cannot get out of bed. Smith has seizures and, on at least two or three occasions, she has kept Smith from hurting herself when having a seizure while walking. Bridges said that she does most of the cooking, cleaning, shopping, and taking care of the children. She indicated that Smith cannot remember things after having a seizure. She administers Smith's medications and the medications for Smith's children. Smith does not drive. (Tr. 35).

[1] Smith described similar limitations in her Disability Supplemental Interview Outline. (Tr. 78-82).

Jerry Miller, a vocational expert (VE), also testified at the hearing. The ALJ asked the VE whether there was any work in the national economy that can be performed by someone with Smith's age, education, and work experience, who has is limited to light work, who has to observe routine seizure precautions, such as avoiding dangerous heights, machinery, operation of automotive equipment, and who has to avoid exposure to dust, fumes, gases, and other pulmonary irritants. The VE testified that such an individual could not work at any of Smith's past jobs, but could work as a cashier II, office helper, or sales attendant. (Tr. 36-37).

B. Medical evidence.

Relevant medical evidence in the record indicates that in a letter to Dr. Lim at Jackson's Medical Clinic dated December 5, 1995, Bob W. Smith, M.D., a clinical neurologist, stated that he had seen Smith on December 1, 1995 for an episode of left hamiparesis. He explained that Smith had a severe headache on the right side with tingling paresthesias in the left face, left arm, and left leg with some motor weakness. An MRI scan of the brain was normal. Dr. Smith believed that this was a cerebrovascular occlusion with resolving ischemic neurologic deficit probably related to migraine phenomenon. He place Smith on a migraine diet, told her to stop smoking, and gave her Mysoline. (Tr. 208-10).

In a letter to Dr. Tabbal at the University Hospital of Arkansas neurology department dated December 27, 1995, Dr. Smith, the clinical neurologist, indicated that he was referring Smith to the UA for a second opinion. He noted

that Smith has a history of focal seizures from age seven to fifteen, for which she had been treated with Mysoline. He stated, "Recently, she has had what I feel to be a migraine related cerebrovascular occlusion." (Tr. 207).

Smith was treated at the White River Rural Health Center on September 20, 1995 for a urinary tract infection following a kidney stone. She was seen again on November 8, 1995 and January 5, 8, and 10, 1996 for breathing difficulties and asthmatic bronchitis. (Tr. 147-51).

On February 1, 1996, Smith was seen at the White River Rural Health Center, after having a burning sensation while urinating. Diagnosis was cystitis, obesity, and tobacco abuse. (Tr. 147).

Smith received treatment at the White River Rural Health Center on February 15, 1996, for pain upon inhaling and exhaling, coughing with discharge, and occasional vomiting. Assessment was asthmatic bronchitis. (Tr. 146).

In a letter to Dr. Lim at Jackson's Medical Clinic dated March 1, 1996, Dr. Smith, the clinical neurologist, stated that he saw Smith in the clinic that day and that she is being followed by the University of Arkansas neurology outpatient clinic. Dr. Smith indicated that the UA clinic recommended that Smith stop her anti-convulsants, but not to drive for six months. Dr. Smith agreed with these recommendations and he referred her back to Dr. Lim for follow up. (Tr. 206).

On March 22, 1996, Smith went to the White River Rural Health Center with complaints of a migraine headaches. She was given Elavil and Paxil. (Tr. 146).

Smith again was treated at the White River Rural Health Center for a urinary tract infection on April 1, 1996. Smith was treated at the center for a kidney stone and bronchitis with bronchospasms on April 11, 1996. She returned with a urinary tract infection on May 14, 1996. (Tr. 143-45).

On August 25, 1997, Smith returned to the White River Rural Health Center for treatment for acute asthma and migraine headaches. On January 30, 1998, Smith complained of numbness in her right arm and leg. Diagnosis was anemia resolved and neuritis. (Tr. 142).

On February 17, 1999, Smith was seen at the Bald Knob Medical Clinic with complaints of tingling in both arms and legs and breathing problems. She was diagnosed with bronchitis with possible asthma and a urinary tract infection. (Tr. 126).

On May 5 and 24, 1999, and on June 25, 1999, Smith was seen at the Bald Knob Medical Clinic for treatment of her depression and anxiety, follow up, and refill of her anti-depressant medication, Paxil. (Tr. 138-39).

Smith went again to the Bald Knob Medical Clinic on June 26, 1999, after suffering a burning sensation in her neck with pain radiating downward. Upper arm strength was good bilaterally. She was tender to touch in the thoracic spine and paraspinous muscles. Assessment was thoracic muscle spasms. (Tr. 134).

Smith followed up for treatment of the kidney stone at the Bald Knob Medical Clinic on July 12, 1999. She was treated again at the Bald Knob Medical Clinic

on July 16, 1999 for a urinary tract infection following a kidney stone. (Tr. 135-36).

Smith's dosage of Paxil was increased on September 7, 1999 by her doctor at the Bald Knob Medical Clinic. (Tr. 130).

Smith was seen at the Bald Knob Medical Clinic on November 1 and 10, 1999 for follow up of her acute asthma exacerbation. She was treated at the clinic again on December 10, 1999 for breathing problems. (Tr. 127-29).

On February 2, 2000, Smith returned to the Bald Knob Medical Clinic with chest congestion, sleep difficulty, and problems walking. Assessment was bronchitis and anxiety. She was given prescriptions for Amoxil and Paxil. (Tr. 124).

Smith was seen at the Bald Knob Medical Clinic on March 8, 2000, after having constant chest pain. She was diagnosed as suffering from costochondritis. (Tr. 123).

On March 30, 2000, Smith was treated at the Bald Knob Medical Clinic for anxiety, crying, insomnia. She was diagnosed with anxiety and irritable bowel syndrome. Smith's doctor at the Bald Knob Medical Clinic refilled her prescriptions for Paxil and Ativan for depression on April 20, 2000. (Tr. 121-22).

On June 7, 2000, Smith was treated at the Bald Knob Medical Clinic after having problems with her left arm and leg. Assessment was transient ischemic attack (TIA). (Tr. 120).

Smith was treated at the Bald Knob Medical Clinic on November 6, 2000 for left side swelling and pain. Her doctor noted that she had a history of stroke and two transient ischemic attacks (TIAs). Diagnosis was headaches, asthma, anxiety, and obesity. She was seen again at the clinic on November 28, 2000 for a refill of medications for asthma. (Tr. 114-15).

On February 13, 2002, medical records from the Bald Knob Medical Clinic indicate that Smith was treated for reactive airway disease, tobacco abuse, shingles of the right forearm, and a situational crisis. (Tr. 224).

Smith was treated at the Bald Knob Medical Clinic on April 19 and 23, 2001 for acute bronchitis. Her doctor also noted that her depression was controlled and that Smith was not having suicidal thoughts. (Tr. 112).

Smith went to the emergency room on April 21, 2001 for treatment of congestion, shortness of breath, and sore throat. She was diagnosed with chronic obstructive pulmonary disease (COPD), bronchitis, and a urinary tract infection. (Tr. 104-07).

Smith was admitted to the emergency room on June 2, 2001, after suffering injuries in an automobile accident. She complained of neck and back pain. Cervical and thoracic spine x-rays were negative. Smith was diagnosed with cervical strain and discharged on pain relievers. (Tr. 99-103).

Smith was treated at the Bald Knob Medical Clinic on June 12, 15, 19, and 21, 2001, for continued pain and muscle spasm in her neck and back after the

automobile accident. She was given Toradol, Naproxen, Ultram, Darvocet N-100, and Lortab for pain and Flexeril for muscle spasms. (Tr. 108-12).

On August 5, 2002, Smith was treated at the Bald Knob Medical Clinic for COPD, seasonal allergies, and acute bronchitis. Her medications were changed on August 27, 2002. (Tr. 195-96).

Smith reported having blackouts to her doctor at the Bald Knob Medical Clinic on September 25, 2002. She indicated that she had seizures as a child. Diagnosis was syncope, loss of consciousness, and depression. She was scheduled for a cartiod artery scan, prescribed Neurontin, and told not to drive. (Tr. 197).

On October 9, 2002, Smith returned to the Bald Knob Medical Clinic after having seizures and right side pain. Assessment was seizure disorder with tonic-clonic seizures, seasonal allergies, and urinary tract infection. (Tr. 198).

An MRI of the cervical spine performed on October 16, 2001 showed a small central disc protrusion at C4-5 with minimal cord effacement and a mild focal central disc bulge at C5-6 without cord compromise. (Tr. 205).

On October 24, 2002, Smith again was treated at the Bald Knob Medical Clinic for seizure disorder, thoracic outlet syndrome, urinary tract infection, and allergies. Her Neurontin was increased and she was given Ultram for pain. (Tr. 199).

Smith next received treatment for her seizure disorder on October 30, 2002 and November 1, 2002 at the Bald Knob Medical Clinic. She indicated she was having daily seizures. She was put on Dilantin. (Tr. 200-02).

On November 26, 2002, Smith was treated at the Bald Knob Medical Clinic for an upper respiratory infection. (Tr. 202).

In a letter dated December 11, 2002, Terry Brown, D.O., one of Smith's treating doctors at the Bald Knob Medical Clinic, stated that Smith has a seizure disorder, with her last seizure being on December 9, 2002. He indicated that she therefore was not allowed to drive under state law. Smith was on Dilantin 100mg three times a day. (Tr. 194).

On January 27, 2003, Smith underwent a consultative evaluation performed by Owen H. Clopton, M.D., an internist, at the request of the Commissioner. Dr. Clopton noted that Smith's medications were Darvocet, Hydroxyzine, Dilantin, Difil-G, Promethazine, Paxil, Nasacort, Pepcid, Flonase, Ibuprofen, Tylenol, Albuterol, and Combivent. A pulmonary function study showed mild restriction with no clear improvement on the post-bronchodilator test. He diagnosed Smith as suffering from recurrent bronchitis, hypertension, migraine headaches with migraine equivalent, mixed anxiety depression, seizure disorder by history (uncontrolled), and exogenous obesity. Based on his assessment, Dr. Clopton indicated that Smith can occasionally lift and carry up to twenty pounds, frequently lift and carry up to ten pounds, stand two hours in an eight-hour workday, and only occasionally climb, balance, kneel, crouch, crawl, and stoop.

Dr. Clopton further indicated that Smith should avoid temperature extremes, dust, humidity, wetness, fumes, odors, chemicals, and gases due to her breathing difficulties. (Tr. 230-42).

Smith was treated for increased seizure activity and confusion by Dr. Bob Smith, a clinical neurologist, at the Heber Springs Family Health Center on February 19, 2003, upon referral from the Bald Knob Medical Clinic. Smith reported having several seizures a week. She also complained of pain radiating into her ankles. Diagnosis was epilepsy, grand mal, uncontrolled, possible chronic sulidural hematoma, obesity, and mental depression. (Tr. 244). In a letter to the Bald Knob Medical Clinic, Dr. Smith stated that Smith suffers from uncontrolled grand mal epilepsy. He ordered an MRI of the brain and an EEG and he requested that her Dilantin level be obtained. Dr. Smith further recommended decreasing Smith's Paxil since it has a tendency to worsen seizure activity. He continued Smith on Dilantin 300mg daily and added Depakote 250mg three times a day. (Tr. 247).

Smith's Dilantin level on February 20, 2003 was low. (Tr. 251).

An EEG performed on February 28, 2003 was interpreted as an essentially normal interseizure EEG. The reading, however, did not rule out the diagnosis of epilepsy. (Tr. 248).

An MRI of the brain performed on February 28, 2003 showed no intercranial lesion. (Tr. 250).

Smith returned to the Heber Springs Family Health Center on March 12, 2003 for follow up of her seizure disorder. Smith's sister reported that she was having fewer seizures, but that they were more intense. Smith had stopped taking Paxil. Diagnosis was seizure disorder, uncontrolled on anticonvulsant therapy, asthma, and obesity. Smith's Dilantin was increased to 400mg per day. (Tr. 243).

C. Administrative proceedings.

The administrative law judge (ALJ) evaluated Smith's claim for benefits according to the familiar five-step analysis prescribed by the Social Security regulations. *See* 20 C.F.R. § 416.920(a)-(g). In a decision dated May 17, 2003, the ALJ made the following findings:

1. Smith has not engaged in substantial gainful activity since her alleged onset date.

2. Medical evidence establishes that Smith has a history of back strain, seizures and mild COPD.

3. Smith does not have an impairment that meets or equals a listed impairment.

4. Smith's subjective complaints are not fully credible. She has the residual functional capacity for light work that includes seizure precautions and avoidance of pulmonary irritants. She is unable to perform her past relevant work as a certified nursing assistant.

5. Based on Smith's age, education, work history, and vocational expert testimony, there are other jobs in the national economy that Smith can perform,

including cashier, office helper, and sales attendant. Therefore, Smith is not disabled within the meaning of the Social Security Act. (AD 1-6; Tr. 9-14).

On August 14, 2003, the Appeals Council denied Smith's request for review. (AD 7-9; Tr. 2-4). Thus the ALJ's decision stands as the final decision of the Commissioner and it is from this decision that Smith seeks judicial review.

SUMMARY OF THE ARGUMENT

Belinda Smith is unable to work due to an uncontrolled seizure disorder, migraine headaches with a migraine-related cerebrovascular occlusion, chronic obstructive pulmonary disease (COPD), and chronic back pain. The ALJ committed two reversible errors in assessing Smith's claim. First, the ALJ failed to accurately describe Smith's functional capacity to the VE. He omitted any restriction on Smith's ability to stand or walk. Dr. Clopton, the Commissioner's own consultative examiner, gave an uncontroverted opinion that Smith is unable to stand or walk for six hours in an eight-hour workday. Second, the ALJ failed to develop the record regarding the severity and frequency of Smith's uncontrolled seizure disorder.

ARGUMENT

THE COMMISSIONER'S DECISION DENYING BELINDA SMITH'S DISABILITY CLAIM IS NOT SUPPORTED BY SUBSTANTIAL EVIDENCE ON THE RECORD AS A WHOLE.

A. Standard of review.

Judicial review of the Commissioner's denial of benefits determines whether the Commissioner has correctly applied the law and whether there is substantial evidence on the record as a whole to support his decision. 42 U.S.C. § 405(g); *Keller v. Shalala*, 26 F.3d 856, 858 (8th Cir. 1994). Substantial evidence is not the same as any evidence; it is less than a preponderance, but enough that a reasonable mind might find adequate to support the Commissioner's conclusion. *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992). Moreover, "[t]he substantial evidence test employed in reviewing administrative findings is more than a mere search of the record for evidence supporting the [Commissioner's] findings." *Gavin v. Heckler*, 811 F.2d 1195, 1199 (8th Cir. 1987). The reviewing court must look for substantial evidence on the record as a whole, which requires the court to "take into account whatever in the record fairly detracts from its weight." *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). Thus, the court must consider the weight of the evidence supporting the Commissioner's decision and how contradictory evidence detracts from that weight. *Gavin*, 811 F.2d at 1199 (noting that Universal Camera requires a "searching inquiry" into how any contradictory evidence balances out). *See Robinson*, 956 F.2d at 838 (emphasizing that the court must "do more than

merely parse the record for substantial evidence supporting the [Commissioner's] decision. [It] also must consider evidence in the record that detracts from the weight of the decision."); *Wilson v. Sullivan*, 886 F.2d 172, 176 (8th Cir. 1989) (reversing the district court's decision because the magistrate failed to take into account the weight of the evidence upon which the ALJ relied and to apply a balancing test to any contradicting evidence).

B. The regulatory framework.

The Commissioner has adopted regulations creating a five-step test to determine whether a claimant is disabled. *See* 20 C.F.R. § 416.920(a)-(g); *Bowen v. Yuckert*, 482 U.S. 137, 140-42 (1987) (describing the process). The first two steps involve threshold determinations as to whether the claimant is not presently working and has an impairment which is of the required duration and which significantly limits her ability to work. 20 C.F.R. § 416.920(a)-(c). In the third step, the medical evidence of the claimant's impairments is compared to a list of impairments presumed severe enough to preclude any gainful work. *See* 20 C.F.R. pt. 404, subpt. P, App. 1. If an impairment matches or is equal to one of the listed impairments, the claimant qualifies for benefits without further inquiry. *Id.* § 416.920(d). If the claimant cannot qualify under the listings, the analysis proceeds to the fourth and fifth steps. At these steps, the inquiry is whether the claimant can do her own past work or any other work that exists in the national economy, in view of her age, education, and work experience. *Id.* § 416.920(e)-(f). If a claimant demonstrates that she cannot perform her past work,

the burden shifts to the Commissioner to show that there are other jobs in the national economy the claimant can perform. *Reed v. Sullivan*, 988 F.2d 812, 815 (8th Cir. 1993). If the claimant cannot do her past work or any other work, she qualifies for benefits.

C. The ALJ's determination at step five that there are other jobs in the economy that Smith can perform is not supported by the record.

Belinda Smith is unable to work due to an uncontrolled seizure disorder, migraine headaches with a migraine-related cerebrovascular occlusion, chronic obstructive pulmonary disease (COPD), and chronic back pain. The ALJ nevertheless determined at step five of the sequential analysis that Smith is not disabled because there are other jobs in the national economy that she can perform. The ALJ's decision is not supported by substantial evidence on the record as a whole.

When a claimant proves, as here, that she cannot return to her past relevant work, the burden shifts to the Commissioner at step five to show that the claimant is capable of performing work that exists in the national economy that is consistent with her medically determinable impairment(s) and her vocational factors of age, education, and work experience. *Reed v. Sullivan,* 988 F.2d 812, 815 (8th Cir. 1993). The Commissioner first must determine the claimant's residual functional capacity (RFC), that is, what she can still do despite her impairments, and then must consider the claimant's age, education, and work experience. 20 C.F.R. Part 404, Subpt. P, App. 2, § 200.00(c); *Reed,* 988 F.2d at 815-16.

Ordinarily, if the findings as to the claimant's RFC, age, education, and work experience fit any of the combinations specified in the Tables in Appendix 2 to 20 C.F.R. Part 404 (otherwise known as the "medical-vocational guidelines" or "grids"), the Commissioner must reach the conclusion (disabled or not disabled) directed by the relevant rule or line of the applicable table. *Reed,* 988 F.2d at 816.

If the claimant, however, suffers from nonexertional impairments that limit her ability to perform the wide range of work at a particular exertional level, the ALJ is required to utilize the testimony of a vocational expert to determine whether the claimant is capable of performing other jobs in the national economy. *Id.* Testimony from a vocational expert is substantial evidence only when the testimony is based on a correctly phrased hypothetical question that captures the concrete consequences of a claimant's deficiencies. *Porch v. Chater*, 115 F.3d 567, 572-73 (8th Cir. 1997). Therefore, the hypothetical question answered by a vocational expert must include all those impairments that are substantially supported by the record as a whole. *Id.*

The ALJ's hypothetical did not accurately state Smith's work-related limitations. Dr. Clopton, the Commissioner's own consultative examiner, was the only doctor of record to state an opinion regarding Smith's ability to work.[2] While he limited Smith to light work, he specifically concluded that Smith can stand or walk at least two hours *but less than six hours* in a normal eight-hour

[2] The ALJ's failure to develop the record regarding Smith's work-related restrictions, especially from Smith's treating doctors, is discussed below.

work day. (Tr. 239). The ALJ included the limitation to light work in the hypothetical, but he *did not mention* any limitation on Smith's inability to engage in prolonged standing.

To perform light work as the ALJ described it in his hypothetical, Smith must be capable of standing or walking six hours in an eight-hour workday. Dr. Clopton says she is not. Under the Commissioner's regulations, light work requires

> lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category when it requires a good deal of walking or standing, or when it involves sitting most of the time with some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, you must have the ability to do substantially all of these activities.

20 C.F.R. § 416.967(b). To be capable of performing light work, a claimant must be able to do "a good deal of walking or standing" in addition to being able to lift up to twenty pounds. This Court in Frankl v. Shalala, 47 F.3d 935 (8th Cir. 1995), recognized that "'[l]ight work requires that a claimant be capable of standing or walking for a total of six hours out of an eight-hour work day." Id. at 937 (citing Social Security Ruling 83-10). Smith's inabilty to stand for six hours in a normal workday, as recognized by Dr. Clopton, precludes her from the full range of light work and that limitation should have been included in the hypothetical.

Not only did the ALJ fail to include any limitation on Smith's ability to stand or walk in the hypothetical to the VE, he failed to discuss that limitation in his written opinion. According to Dr. Clopton's uncontroverted opinion, Smith has a significant limitation on her ability to stand and walk. At the very least, the ALJ should have discussed that limitation and given reasons for rejecting it. The ALJ apparently succumbed to the temptation to "play doctor" and made his own independent medical findings, but offered no explanation for doing so. See Delrosa v. Sullivan, 922 F.2d 480, 484 (8th Cir. 1991) (holding that it is improper for an ALJ to substitute his "own unsubstantiated conclusions" regarding claimant's medical condition for that of physician); Ness v. Sullivan, 904 F.2d 432, 435 (8th Cir. 1990) (noting that the ALJ must not substitute his opinions for those of the physician).[3]

The second reason that the ALJ's hypothetical is deficient is that it omits any reference to the the frequency and severity of Smith's seizures. Testimonial and medical evidence shows that Smith suffers from an uncontrolled seizure disorder that results in several seizures a week. (Tr. 29-30, 194, 200-02, 243-44). While a seizure disorder requires that a person take work precautions, it also causes work interruptions. To make a proper assessment of Smith's ability to perform other work, the VE needed to know the frequency and severity of Smith's seizures, as well as the need for workplace precautions. Unfortunately, the ALJ did not have

[3] While Dr. Clopton's opinion was received after the hearing, the ALJ could have sent post-hearing written interrogatories to the VE that included Dr. Clopton's limitation on Smith's ability to stand and walk.

the additional medical information necessary to accurately describe Smith's seizure disorder because he failed to properly develop the record.

D. The ALJ failed to develop the record regarding Smith's seizure disorder.

Belinda Smith was not represented by an attorney when her claim was considered by the agency. The medical evidence summarized above shows that she suffers from an uncontrolled seizure disorder. The ALJ failed to properly develop the record regarding Smith's seizure disorder.

The administrative hearing is not an adversarial proceeding. *Battles v. Shalala,* 36 F.3d 43, 44 (8th Cir. 1994). The ALJ has a duty to develop facts fully and fairly, and this duty is enhanced when the claimant is not represented by counsel. *See Battles*, 36 F.3d at 44; *Mitchell v. Shalala,* 25 F.3d 712, 714 (8th Cir. 1994); *Boyd v. Sullivan*, 960 F.2d 733, 736 (8th Cir. 1992); *see also Highfill v. Bowen,* 832 F.2d 112, 115 (8th Cir. 1987) (emphasizing that claimant's lack of counsel enhances "ALJ's duty to bring out the relevant facts"). The ALJ's duty includes ordering an examination if the claimant's records do not provide enough information. *Boyd,* 960 F.2d at 736. Moreover, as this Court emphasized in Battles, "'[a]n adequate hearing is indispensable because a reviewing court may consider only the [Commissioner's] final decision [and] the evidence in the administrative transcript on which the decision was based.'" 36 F.3d at 45 (quoting Higbee v. Sullivan, 975 F.2d 558, 562 (9th Cir. 1992)). When the ALJ has failed to fully develop the record, this Court has required the Commissioner

to reopen the case until the evidence is sufficiently clear to make a fair determination as to whether or not the claimant is disabled. See Payton v. Shalala, 25 F.3d 684, 686 (8th Cir. 1994) (requiring the record to be developed to the point where "the evidence is sufficiently clear to make a fair determination as to whether or not the claimant is disabled").

The medical evidence of Smith's seizures was more than sufficient in this case to obligate the ALJ to develop the record further regarding the severity and frequency of Smith's seizures. This information was necessary for the ALJ to properly evaluate Smith's claim at both step three and step five of the sequential analysis. See Cox v. Apfel, 160 F.3d 1203, 1209-10 (8th Cir. 1998) (holding that ALJ's failure to develop record was reversible error when it did not contain enough evidence to determine impact of claimant's impairment on her ability to work). The ALJ failed to obtain any additional information from Smith's doctors at the Bald Knob Medical Clinic or the Heber Springs Family Health Center, and especially from Dr. Smith, the claimant's treating neurologist. The Commissioner's regulations provide:

> (e) Recontacting medical sources. When the evidence we receive from your treating physician or psychologist or other medical source is inadequate for us to determine whether you are disabled, we will need additional information to reach a determination or a decision. To obtain the information, we will take the following actions.
>
> > (1) We will first recontact your treating physician or psychologist or other medical source to determine whether the additional information we need is readily available. We will seek additional evidence or clarification from your medical source when the report from your medical source contains a conflict or ambiguity

> that must be resolved, the report does not contain all the necessary information, or does not appear to be based on medically acceptable clinical and laboratory diagnostic techniques . . . .

20 C.F.R. § 416.912(e). See Barrett v. Shalala, 38 F.3d 1019, 1023 (8th Cir. 1994) (noting duty of ALJ to order additional tests when "the medical records presented to him do not give sufficient medical evidence to determine whether the claimant is disabled"); see also Schall v. Apfel, 134 F.3d 496, 505 (2d Cir. 1998) ("[E]ven if the clinical findings were inadequate, it was the ALJ's duty to seek additional information from [the treating physician] sua sponte."). Given the extensive treatment Smith received for her seizures in this case, if her doctors had not specifically commented on her work-related restrictions, the ALJ was obligated to contact them for "additional evidence or clarification," Bowman v. Barnhart, 310 F.3d 1080, 1085 (8th Cir. 2002) (quoting 20 C.F.R. § 404.1512(e)) (internal quotations omitted), and "for an assessment of how the impairments limited [Smith's] ability to engage in work-related activities.'" Id. (quoting Lauer v. Apfel, 245 F.3d 700, 706 (8th Cir. 2001)). Without this information, the ALJ was not able to properly assess Smith's seizure disorder or accurately describe it to the VE.

CONCLUSION

For the reasons set forth above, the Commissioner's decision that Belinda Smith is not disabled is not supported by substantial evidence. The final decision of the Commissioner should be reversed and appropriate benefits

awarded or, in the alternative, the case should be remanded for proper evaluation of Smith's claim.

Respectfully submitted,

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**CERTIFICATE OF COMPLIANCE WITH FRAP 32(a)(7)
AND EIGHTH CIR. R. 28A**

The undersigned hereby certifies that this brief complies with Federal Rule of Appellate Procedure 32(a)(7) regarding type and volume limitations. The word count is 5,515. The word processing software used is Microsoft Word X for the Macintosh. A copy of the brief has been provided to the Court and Appellee's counsel on CDs. The brief has been converted to Adobe PDF format. The CDs have been scanned for viruses and are virus free.

E. Gregory Wallace

May 17, 2005

CERTIFICATE OF SERVICE

I, E. Gregory Wallace, do hereby certify that I have served a copy of the above and foregoing document on the defendant by mailing a copy of the same to Stacey E. McCord, Assistant U.S. Attorney, P.O. Box 1229, Little Rock, Arkansas, 72203, on this 17th day of May 2005.

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E. Gregory Wallace

ADDENDUM

INDEX TO ADDENDUM